Testimony before the Senate Select Committee on Indian Affairs

Thursday, February 26, 2009

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Good morning, Honorable Chairman Dorgan and Vice-Chairman Barrasso and Honorable Members of the Committee. Thank you for your invitation to personally testify before this committee and to present my views concerning progress made in the area of preventing American Indian and Alaska Native (AI/AN) youth suicidal behavior.

I come before you as a professor of Counseling Psychology, a mother of an enrolled member of the Turtle Mountain Band of Chippewa, the developer and evaluator of a suicide prevention program entitled the *American Indian Life Skills*, a researcher of ethnic identity and mental health, and a former elementary and secondary teacher in urban and reservation schools. I hope that my testimony will assist the Committee in taking stock of the potential for evidence-based school and community interventions to prevent AI/AN youth suicide and promote positive AI/AN mental health.

In the 21st Century, suicide continues to be a vivid manifestation of distress among Native people. Untimely death accounts for almost one in five deaths among AI/AN youth 15- to 19-years of age. This proportion is considerably higher than that of youth from other ethnic groups or the general population (Centers for Disease Control, 2006). Completed suicide is 72% more common among AI/AN people than the general population (Indian Health Service, 2001). The estimated rate of completed suicides among AI/AN youth ages 5 to 14 years

is 2.1 per 100,000, compared to 0.8 per 100,000 for all US youth in the same age group; the rate of completed suicides among AI/AN youth ages 15 to 24 years is 37.4 per 100,000, compared to 11.4 per 100,000 for all US youth in the same age group (Indian Health Service, 2002).

In recent years federal efforts such as the Surgeon General's Call to Action and the National Strategy for Suicide Prevention (U. S. Department of Health and Human Services, 1999, 2001) have reflected growing concern over youth suicide within the US. Hearings on Indian youth suicide sponsored by this Committee have provided a forum for citizens to advocate for greater attention and services for those AI/AN youth who elect not to seek help for suicidal ideation due to stigma or embarrassment, who seem to lack regard for the deadly consequences of their behavior, and whose suicidal intent goes unrecognized, unappreciated, and untreated.

Funds appropriated by the Garrett Lee Smith Memorial Act have served as a catalyst for the mobilization of suicide prevention programs in many AI/AN communities at highest risk for suicide. I have been fortunate to work with three SAMHSA funded programs for AI/AN youth suicide prevention . I designed a Training of Trainers program with staff from Native Aspirations (JoAnn Kauffman, PI) to train community members from 30 reservations in regional training in Wolf Point, MT, Rosebud, SD, Pine Ridge, SD, and Anchorage, AK. I was also supported by the Indian Country Child Trauma Center (Dee BigFoot, PI) to develop and field test a middle school version of the *American Indian Life Skills* on the Omaha reservation. As a consultant to the Helping Hands Project of the Puyallup tribe (Danelle Reed Inderbitzen, PI), I worked with mental health workers from the tribal health authority who worked in tandem with 6th grade teachers at their tribal school to field test the middle school version of *AILS*.

Through these experiences I worked with some incredible AI/AN interventionists and witnessed directly the power of traditional healing in conjunction with effective conventional psychological practices. However, I also observed the frustration of tribal leaders at the slowness with which these programs have reached AI/AN communities.

As a psychologist, I realize that the psychological risk for suicidality includes co-morbidity with psychiatric and substance use disorders. However, as a counseling psychologist who studies learning and adaptation, I believe that decisions related to suicidal behavior among the majority of AI/AN youth may be attributed to direct learning or modeling influences (e.g., family, peer, extended family suicide attempts/deaths by suicide) in conjunction with certain contextual sources (e.g., perceived discrimination, historical trauma, acculturation stress) and individual characteristics (e.g., depression, PTSD). I also believe that many risk factors for suicide are similar to risk factors for other problematic behaviors such as alcohol and drug abuse or engaging in unsafe sex. When cast from this more social cognitive perspective, suicide and other forms of risk behavior are more likely to be preventable.

SUICIDE PREVENTION AND TREATMENT FOR AI/AN YOUTH

"The goal of most prevention programs is to assist an individual in fulfilling their normative and developmentally appropriate potential including a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen their ability to cope with adversity" (National Research Council and Institute of Medicine, 2009, p. 74). Five programs, targeting AI/AN youth suicide, have been featured in noted reviews of suicide prevention (National Academy of Sciences, 2002; Goldston, Molock, Whitbeck, Murakami, Zayas, & Hall, 2008). These include: *The Zuni Life Skills Development Curriculum*

(LaFromboise & Howard-Pitney, 1994), *the Wind River Behavioral Program* (Tower, 1989), the *Tohono O'odham Psychology Service* (Kahn, Lejero, Antone, Francisco, & Manuel, 1988), the *Western Athabaskan Natural Helpers Program* (May, Serna, Hurt, & DeBruyn, 2005), and the *Indian Suicide Prevention Center* (Shore, Bopp, Waller, & Dawes, 1972). These prevention programs incorporate positive messages regarding cultural heritage that increase self-esteem and sense of mastery among AI/AN adolescents and focus on protective factors in a culturally appropriate context. They provide strong grounding for adolescent pro-social behaviors through close ties with extended family involvement and resilient elders. They also integrate tribal leaders in the prevention effort and encourage youth to use traditional ways of seeking social support (May, et al., 2005).

These programs privilege AI/AN ways of knowing, behavioral expectations, attitudes and values and encourage youth to be embedded in cultural practices. For the most part, suicide prevention programs that incorporate cultural teachings and traditions into the psychological intervention have been well-received by AI/AN communities and some are found to have promising outcomes. Research has shown that enculturation is positively related to protective factors such as academic success and pro-social behaviors (Whitbeck, Hoyt, Stubben, & LaFromboise, 2001) and negatively related to depression (LaFromboise, Albright, & Harris, forthcoming). One of the complexities in implementing these interventions across tribal groups is the extent of major cultural differences between more than 560 different tribes. However, researchers who struggle with the problem of lack of generalizability of prevention programs are exploring efforts to identify common elements among

tribes with closely related traditions that could be incorporated into prevention programs on a wide scale basis (See Mohatt et al., 2004; Allen et al., 2006).

PREVENTION INTERVENTION IN AI/AN COMMUNITIES

Within mainstream society and a few select cultural groups there has been considerable evidence for the positive effects of family, school, and community prevention interventions to increase the resilience of youth and reduce their risk for mental, emotional, and behavioral disorders. A recent report just released by the National Academy of Sciences (2009), entitled *Preventing Mental, Emotional and Behavioral Disorders among Young People,* highlights interventions designed to prevent many of the common correlates of suicidal ideation (e.g., depression, substance abuse, interpersonal conflict, constricted thinking). The recommended interventions also focus on strengthening families, improving social relationships, and reducing aggressive behavior and school-based violence. I believe that some of the prevention programs featured in this report could provide a mechanism for advancing suicide prevention efforts in Indian Country.

I cannot give this testimony without also advocating for the expansion of social emotional learning in AI/AN schools. I realize that schools are often overloaded with other academic-related priorities. However, social emotional development programs in schools have been found to have a positive impact on academic outcomes, especially among elementary school-age children. Research by Durlak and colleagues (2007) indicated that the effects of social and emotional learning programs were equivalent to a 10 percent point gain in test performance. Students who also participated in this intervention research demonstrated improvements in school engagement and grades.

Unfortunately, few of the interventions showcased in the National Academy report have been implemented in Indian Country. Evidence has been

found for long-term results of a few of the interventions with African American and Latino-Latina youth. No doubt that given the unique historical context of AI/AN communities, there is resistance to the mere transposing of evidence based interventions onto prevention programs with AI/AN youth. It is essential for AI/AN researchers to assess whether the relevant recommended prevention interventions featured in this report are generic enough to be found effective with AI/AN youth. Furthermore, AI/AN researchers should work to culturally adapt evidence based interventions while maintaining the critical core content and dosage of the intervention.

RECOMMENDATIONS

1. Allocate federal funds for a technical assistance center to provide training in the implementation and evaluation of evidence based prevention interventions in Indian Country. This center could assist in improving the cultural competence of service providers in terms of knowledge of the relevant risk and protective factors for suicide among AI/AN youth. This center would encourage the expansion of AI/AN community-based research collaborations.
2. Expand social emotional development activities in AI/AN schools throughout the course of Kindergarten through 12th grade.
3. Increase the number of AI/ANs in the fields of psychology, social work, public health, medicine, and education to further advancement of prevention efforts in Indian country.

References will be provided upon request.